

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

8377

1. PLACE OF DEATH

County

Township

City

(No.

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1
day,hrs.
ormin.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year).....11. Total time (years)
spent in this
occupation.....12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19. UNDERTAKER
(ADDRESS)

20. FILED

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on

to have occurred on the date stated above, at

The principal cause of death and related causes of importance were as follows:

Diabetes

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. D.

RECEIVED

District Health Officer No. 2,

District File Number 340-69

Date Filed 3/7/40

RECEIVED

District Health Officer No. 2,

District File Number

Date Filed

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. **8377**DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSRegistration District No. **839**Primary Registration District No. **6101**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County **Sheldon**
 (b) City or town **Richland**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____
years, months or days)3. (a) PRINT FULL NAME **E. Ward**

3. (b) If veteran,
- m.m.o.**
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex
- m**
-
- Color or race
- w**

6. (a) Single, widowed, married,
-
- divorced
- wid**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if
-
- alive _____ years

7. Birth date of deceased _____
-
- (Month) (Day) (Year)

8. AGE: Years
- 75**
- Months _____ Days _____
-
- If less than one day _____ hr. _____ min.

9. Birthplace _____
-
- (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____
 13. Birthplace _____ (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
-
- (b) Address _____

17. (a) _____ (b) Date thereof _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address
- 918 4th St. Borden**

- (c) (Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____
-
- (If outside city or town limits write "RURAL")

- (d) Street No. _____
-
- (If rural, give location)

- (e) If foreign born, how long in U. S. A. ? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month
- 2**
- day
- 5**
-
- year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

- Due to _____

- Due to _____

- Other conditions _____
-
- (Include pregnancy within 3 months of death)

- Major findings:
-
- Of operations _____

- Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

- While at work? _____ (Specify type of place)
-
- (e) Means of injury _____

23. Signature
- W. F. Hays**
- (M. D. or other) _____

- Address
- Essex Mo**
- Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY